RAE #14

Minnesota Department of Corrections

Division Directive:	**500.045**	**Title: Health Record Documentation**
Issue Date:	**11/5/13**	
Effective Date:	**11/19/13**	

AUTHORITY: Policy 500.010, "Health Services"

PURPOSE: To provide standards for documentation of offender medical and dental records.

APPLICABILITY: Minnesota Department of Corrections (DOC); all staff who document in an offender's medical or dental record

DIRECTIVE: All staff must document in the offender's medical or dental record for each patient encounter, including staff responses regarding medical or dental actions taken or recommended due to receipt of offender kites. The health authority must approve the method of recording entries in the record, form and format of the record, and procedures for health record maintenance and safekeeping.

DEFINITIONS:

Encounter - a contact between the offender and a health services staff with the responsibility for assessing and/or treating the patient.

Health record - the offender-specific medical or dental record that is compiled during the course of patient care (mental health record documentation is addressed in Policy 500.307, "Mental Health Records"). The health record is available to, and used by, all health care practitioners. Health records include:

A. Offender identification on each sheet;
B. Completed receiving screening form;
C. Health appraisal data forms;
D. Problem summary list;
E. Record of immunizations;
F. All findings, diagnoses, treatments, and dispositions;
G. Record of prescribed medications and administration records;
H. Laboratory, X-ray, and diagnostic studies;
I. Place, date, and time of health care encounters;
J. Health service reports (i.e., emergency department, dental, mental health, telemedicine, or other consultations);
K. An individual treatment plan, when applicable;
L. Progress reports;
M. A discharge summary of hospitalization and other termination summaries;
N. Informed consent and refusal forms; and
O. Release of information forms.

Kite – see Division Directive 303.101, "Kites/Communication."

Staff - health care employees of the State of Minnesota or health care professionals (e.g., physicians, physician's assistant, dentists, licensed nurses, nurse practitioners, certified medical assistants, medical record personnel, and registered dietitians) under signed contract with the State of Minnesota to provide professional health care assessments, examination, and/or treatment to offenders.

PROCEDURES: Staff must:

A. For staff/offender encounters, documentation must include a health record entry containing:
   1. Subjective information;
   2. Objective findings;
   3. Assessment of the problem; and
   4. Plan including education offered.

B. Documentation of kites must contain significant clinical information in the progress notes.
   1. Health service administrator/designee can determine whether it is important to retain a kite as a part of the medical record.

   2. Kites for medication refills, requests for record copying, requests for lab tests or sick call, repeat requests for resolved issues, requests for immunizations or expressions of thanks do not need to be documented in the medical record unless directed by the health services administrator/designee.

C. Enter all significant clinical information into the health record immediately or prior to completion of shift.

D. Sign all entries after each document and include name or first initial, last name, and title.

E. Not alter information entered in the medical record by another staff.

F. Make corrections by drawing a single line through the entry, add the date the correction is made and initial. Do not obliterate chart entries. No other notations are necessary.

G. Legibly document all encounters in black or blue ink. Do not use erasable pens, felt pens, markers, or correction fluid/tape.

H. Not leave blank spaces between lines of charting.

I. Date each health record entry with month, day, year, and time of entry (A.M., P.M., or military time).

J. Not document name(s), offender identification number (OID), or identification of another offender. Document reference to staff using name and title.

K. Record late entries with the date and time of documentation as well as the actual date and time of occurrence. Do not make reference to late entry.

L. Practitioners must review, initial and date all lab, radiology, test results, and reports from outside providers as soon as possible after receipt prior to filing in the health record.

M. Check the health record for proper offender name and OID prior to making any entry.

N. Use only approved abbreviations; see Approved Abbreviations List (attached).

O. Document informed consent obtained by practitioner to include explaining to the patient any risks, benefits, and/or alternatives which may exist relative to the procedure in terms and a language that the patient can reasonably be expected to understand.

P. File dictated reports with the legend:
1. Date dictated;
2. Date transcribed; and
3. Initials of the transcriber.

Q. The health services administrator maintains a current original Master Signature List (attached) compiled of all register nurse (RN), licensed practical nurse (LPN), certified medical assistant (CMA), certified athletic trainer, and practitioner staff working at his/her site. This allows practitioners to initial labs, etc. after review; this also allows nursing staff to use only initials on the immunization record. Full names as noted above are required on all other documents in the medical record.
1. New employees are added at the time of hire, including transferring employees.
2. A new signature sheet is generated annually.
3. Central office health services maintains a copy.

INTERNAL CONTROLS:

A. Health services staff performs annual documentation audits, which are maintained in the registered nurse supervisor's file.

REVIEW: Annually

REFERENCES:
AHIMA Practice Brief Document 409, September 1996
ACA Standards 4-4397 and 4-4413
Policy 500.050, "Health Screenings and Full Health Appraisals"
Division Directive 500.190, "Health Care Data Practices"
Policy 106.210, "Data Practices"
Minn. Stat. §145.32, subd. 1
Policy 500.307, "Mental Health Records"
Division Directive 303.101, "Kites Communication"
Prison Rape Elimination Act (PREA), 28 C.F.R. §115 (2012)

SUPERSESSION: Policy 500.045, "Health Record Documentation," 8/20/13.
All facility policies, memos, or other communications whether verbal, written, or transmitted by electronic means regarding this topic.

ATTACHMENTS:
Minnesota Department of Corrections Approved Abbreviations List (500.045A)
Authorization for Medical and/or Minor Surgery Procedures (500.045B)
Master Signature List (500.205D)

/s/ Terry Carlson
Deputy Commissioner, Facility Services

Minnesota Department of Corrections

Division Directive:	**500.185**	**Title: Transfers for Needed Care**
Issue Date:	**11/5/13**	
Effective Date:	**11/19/13**	

AUTHORITY: Minn. Stat. §241.01, subd. 3a

PURPOSE: To ensure availability of required medical resources to maintain offender health care.

APPLICABILITY: Minnesota Department of Corrections (DOC); all facilities

DIRECTIVE: Offenders who need health care beyond the resources available in the facility, as determined by the medical practitioner and facility health services administrator, are transferred under appropriate security provisions to a facility where such care is available. Transfers for emergency outside care are available 24 hours a day.

DEFINITIONS: None

PROCEDURES:

A. The medical practitioner must:
   1. Assess the offender's medical condition and review with the facility's health services administrator/designee to determine the appropriate level of care, including the need for transporting the offender to an appropriate location where required medical services are available; and
   2. Provide orders as indicated for necessary care of the offender's health care needs.

B. The health services administrator/designee must:
   1. Whenever possible, discuss the need to transfer an offender in consultation with the medical practitioner;
   2. Inform the potential receiving facility's health services administrator/designee of the offender's medical condition, medical services required, and prescribed orders as written by the medical provider;
   3. Notify the watch commander and transfer coordinator of a required medical transfer to another facility and communicate the following information:
      a) The timeliness of the required medical transfer;
      b) Mode of transportation required (ambulance, MediVan, van, etc.);
      c) Medical care necessary during transport; and
      d) Location of receiving facility; and
   4. Approve the offender's return to the sending facility (prior to the offender's departure from the receiving facility), after determining if the required medical care has been completed or is available at the sending facility.

C. Security staff must determine security measures needed during transportation with consideration of the offender's medical condition and potential need for modifications due to the medical condition.

D. Facility records staff must:

1. Obtain all necessary records and package the necessary records for transfer to another department facility; and
2. Complete necessary transfer form(s).

E. Nursing staff must:
1. Package medications including the medication administration records and any needed and available medical supplies if the offender is transferred to another department facility;
2. Provide copies of all pertinent medical records to the receiving facility if outside the department; and
3. Complete the necessary forms and include with the medical, dental, and behavioral health record prior to transfer.

INTERNAL CONTROLS:
A. Documentation of transfers for needed care, and the rationale, is located in the medical record.

REVIEW: Annually

REFERENCES: ACA Standards 4-4348, 1-ABC-4E-38, 1-ABC-4E-39
Division Directive 301.095, "Central Transportation-Offenders"
Division Directive 203.220, " Special Duties"
Division Directive 500.180, "Medical Transfer Process"
Division Directive 500.520, "Tuberculosis Prevention and Control for Offenders"

SUPERSESSION: Policy 500.185, "Transfers for Needed Care," 7/5/11.
All facility policies, memos, or other communications whether verbal, written, transmitted by electronic means regarding this topic.

ATTACHMENTS: None

/s/ Terry Carlson
Deputy Commissioner, Facility Services

Instructions
500.185-1WRML, Medical Concerns After Hours at Willow River Moose Lake"
500.185OPH, "Hospice Program"

Security Instructions
500.185-1OPH, Emergency Special Duties"